

MISSOURI STATE BOARD OF HEALTH
BUREAU OF VITAL STATISTICS
CERTIFICATE OF DEATH

Do not use this space.

3633

1. PLACE OF DEATH

County..... Registration District No. 791
 Township..... Primary Registration District No. 1008
 City St. Louis Mo. (No. Missouri Hospital Saddle Creek St. 228 Ward)

2. FULL NAME

James L. Holbrook
 (a) Residence No. 4351 Sennel Ave. St. 15 Ward.
 (Usual place of abode)
 Length of residence in city or town where death occurred 25 yrs. mos. ds. How long in U.S., if of foreign birth? yrs. mos. ds. (If nonresident give city or town and State)

PERSONAL AND STATISTICAL PARTICULARS

3. SEX Male 4. COLOR OR RACE White 5. SINGLE, MARRIED, WIDOWED OR DIVORCED (write the word) Married

5A. IF MARRIED, WIDOWED, OR DIVORCED HUSBAND OF (or) WIFE OF Etta M. Holbrook

6. DATE OF BIRTH (MONTH, DAY AND YEAR) Sept 25, 1873

7. AGE YEARS MONTHS DAYS If LESS than 1 day, hrs. or min.
55 3 9 1

8. OCCUPATION OF DECEASED Chief Mail Clerk
 (a) Trade, profession, or particular kind of work
 (b) General nature of industry, business, or establishment in which employed (or employer) 9th & Olive
 (c) Name of employer

9. BIRTHPLACE (CITY OR TOWN) New York
 (STATE OR COUNTRY)

10. NAME OF FATHER J. R. Holbrook

11. BIRTHPLACE OF FATHER (CITY OR TOWN) New York
 (STATE OR COUNTRY)

12. MAIDEN NAME OF MOTHER Unknown

13. BIRTHPLACE OF MOTHER (CITY OR TOWN) New York
 (STATE OR COUNTRY)

14. INFORMANT Etta M. Holbrook
 (Address) 4351 Sennel Ave.

15. FILED 14N -5, 1929 Map C. Thomas REGISTRAR

MEDICAL CERTIFICATE OF DEATH

16. DATE OF DEATH (MONTH, DAY AND YEAR) 1/4/29 19

17. I HEREBY CERTIFY, That I attended deceased from 12/6/28 19, to 1/4/29 19, that I last saw h. MAN alive on 1/4/29 19, and that death occurred, on the date stated above, at 8 a. m.

THE CAUSE OF DEATH* WAS AS FOLLOWS:
108 Chronic Nephritis
131

101 (duration) yrs. 6 mos. ds.

CONTRIBUTORY (SECONDARY) Pneumonia
Lobar (duration) yrs. mos. 10 ds.

18. WHERE WAS DISEASE CONTRACTED ?
 IF NOT AT PLACE OF DEATH?.....

DID AN OPERATION PRECEDE DEATH? no DATE OF.....

WAS THERE AN AUTOPSY? no

WHAT TEST CONFIRMED DIAGNOSIS? Urinaly exam
 (Signed) Dr. Allen R. Peterson, M. D.
 , 19 (Address) 4960 Saddle

*State the DISEASE CAUSING DEATH, or in deaths from VIOLENT CAUSES, state (1) MEANS AND NATURE OF INJURY, and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

19. PLACE OF BURIAL, CREMATION, OR REMOVAL Carthage Mo. DATE OF BURIAL 1/6/29 19

20. UNDERTAKER Kreyshauer & Co ADDRESS 4104 Manchester

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

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